Massachusetts Commission for the Deaf and Hard of Hearing
CART Provider Request Fax Form

(Items marked with a diamond (◆) REQUIRED for form to be complete)

incomplete forms cannot be processed

Please fax to (617) 740-1880

◆ Today's Date:	◆ Your Name:
◆ Your Phone #: **Ext.**	◆ Your Fax #:
◆ Your Agency:	
◆ Date(s) of Assignment:	
◆ Beginning Time of Assignment:	◆ End Time of Assignment:
◆ Location/Address of Assignment: (include bldg., floor, and room #)	
◆ On-site Contact Person:	◆ Phone # On-site: **Ext.**
◆ Description of Situation/Nature of Assignment (if follow up, please describe):	
◆ Names of Deaf or Hard of Hearing Person(s):	
Requested CART Reporters (unless otherwise specified by requestor, Referral Service will also check with other qualified Providers if requested Providers are unavailable):	
Total # of Participants	Other Agencies Involved:

Equipment: Please check # of users

1-2 users - laptop: _____
1-3 users – monitor: _____
More than 3 users – projector: _____

Please check if equipment loan is needed: _____
Combo projector: _____
LCD plate: _____
Screen: _____

Billing Information
(Request will NOT be processed without billing information)

◆ Contact Person:	◆ Phone Number: **Ext.**	
◆ Agency Name:		
◆ Street Address:		
◆ City:	◆ State:	◆ Zip:

I have read MCDHH Interpreter/CART Referral Service Policies and Procedures, and, by signing my name below, a)I certify that all information is correct and b)I agree to adhere to all terms and conditions.

_____ _____
Signature Date

_____ _____
Print Name **Title**

OFFICE USE ONLY

Area:	Job #:
Received By:	Entered By: